CLAIMS AND APPEALS

Below are the *claims* and *appeals* procedures and requirements for the Arizona Metropolitan Trust Employee Benefit Plan.

TIME LIMIT FOR FILING CLAIMS

All *claims* must be received by the *Plan* within twelve (12) months from the date of *incurring* the expense.

The *Plan's* representatives will follow administrative processes and safeguards designed to ensure and to verify that benefit *claim* determinations are made in accordance with governing plan documents and that, where appropriate, the *Plan* provisions have been applied consistently with respect to similarly situated *claimants*.

There are four (4) types of *claims* covered by the procedures in this section:

1. **Pre-Service Claim.** Some *Plan* benefits are payable without a financial penalty only if the *Plan* approves services **before** services are rendered. These benefits are referred to as *pre-service claims* (also known as *pre-certification* or prior authorization). The services that require *pre-certification* are listed in the **Health Care Management Program** section of this document.

2. **Urgent Care Claim.** An *urgent care claim* is a *claim* (request) for medical care or treatment in which:

    a. applying the time periods for *pre-certification* could seriously jeopardize the life or health of the individual or the ability of the individual to regain maximum function
    b. in the opinion of a *physician* with knowledge of the individual's medical condition, would subject the individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *claim*
    c. the *claim* involves urgent care

3. **Concurrent Care Claim.** A *concurrent care claim* refers to a *Plan* decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment. A *concurrent care claim* also refers to a request by you to extend a pre-

approved course of treatment. Individuals will be given the opportunity to argue in favor of uninterrupted continuity of care before treatment is cut short.

4. **Post-Service Claim.** *Post-service claims* are *claims* that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard *claim* and an electronic bill, submitted for payment after services have been provided, are examples of *post-service claims*. A *claim* regarding rescission of coverage will be treated as *post-service claim*.

Following is a description of how the *Plan* processes *claims* for benefits and reviews the *appeal* of any *claim* that is denied.

If a *claim* is denied, in whole or in part, or if *Plan* coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an *adverse benefit determination*.

A *claimant* has the right to request a review of an *adverse benefit determination*. This request is an *appeal*. If the *claim* is denied at the end of the *appeal* process, as described below, the *Plan's* final decision is known as a *final internal adverse benefit determination*. If the *claimant* receives notice of a *final internal adverse benefit determination*, or if the *Plan* does not follow the *appeal* procedures properly, the *claimant* then has the right to request an independent *external review* for certain limited types of *claims*.

External review is only available if the *final internal adverse benefit determination* involves a *claim*: (1) denied based upon a rescission of coverage or (2) which involves medical judgment (*medical necessity*, appropriateness of treatment, health care setting, level of care, or effectiveness of covered benefit) or a determination that treatment is *experimental* or *investigational*, which is to be decided by the external reviewer. There is no external appeal for *adverse benefit determinations* that a person is not eligible for coverage under the *Plan*.
The *external review* procedures are described below.

Both the **Claims and the Appeal** procedures are intended to provide a full and fair review. This means, among other things, that *claims* and *appeals* will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

A *claimant* must follow all **Claims and Appeals** procedures both internal and external, before he or she can file a lawsuit. However, this rule may not apply if the *Plan Administrator* has not complied with the procedures described in this section. If a lawsuit is brought, it must be filed within two (2) years after the final determination of an *appeal*.

Any of the authority and responsibilities of the *Plan Administrator* under the **Claims and Appeal** procedures or the *external review* process, including the discretionary authority to interpret the terms of the *Plan*, may be delegated to a third party. If you have any questions regarding these procedures, please contact the *Plan Administrator*.

Appropriate Claim Administrator
The chart below outlines the companies acting as the appropriate *Claim Administrator* and types of *claims* managed.

Appropriate Claim Administrator	Types of Claims Processed
Claims Administrator	Medical first-level *post-service claims*
Plan Administrator	Medical, Prescription, Dental, and Vision second-level *post-service claims*
Medical Management Administrator	Medical urgent care, *concurrent care,* and other *pre-service claims*
Prescription Drug Benefits Administrator	First-level *post-service claims* for retail drugs
Dental Plan Administrator (refer to dental plan document)	Dental pre-service and first-level post-service claims
Vision Plan Administrator (refer to vision plan document)	Vision post-service claims
Plan Administrator	Eligibility claims

Assignment of Benefits
An *assignment of benefits* is an arrangement by which a patient requests that their health benefit payments under this *Plan* be made directly to a designated medical *provider* or facility. By completing an *assignment of benefits,* the *plan participant* authorizes the *Plan Administrator* to forward payment for a covered procedure directly to the treating medical *provider* or facility. The *Plan Administrator* expects that an *assignment of benefits* form to be completed, as between the *plan participant* and the *provider*.

Types of Claims Managed by the Medical Management Administrator
There are three (3) types of *claims* managed by the *Medical Management Administrator*; those are:

1. *urgent care claims*
2. *concurrent care claims*
3. other *pre-service claims*

The process and procedures for each *pre-service claim* type are listed below.

Urgent Care Claims
Any *pre-service claim* for medical care or treatment which, if subject to the normal timeframes for *Plan* determination, could seriously jeopardize the *claimant's* life, health, or ability to regain maximum function or which, in the opinion of a *physician* with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *claim*. Whether a *claim* is an *urgent care claim* will be determined by an individual acting on behalf of the *Plan* applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

However, any *claim* that a *physician,* with knowledge of the *claimant's* medical condition, determines is an *urgent care claim* (as described herein) shall be treated as an *urgent care claim* under the *Plan*. *Urgent care claims* are a subset of *pre-service claims*.

How to File an Urgent Care Claim

In order to file an *urgent care claim,* you or your *authorized representative* must call the *Medical Management Administrator* and provide the following:

1. information sufficient to determine whether, or to what extent, benefits are covered under the *Plan*
2. a description of the medical circumstances that give rise to the need for expedited review

If you or your *authorized representative*s fail to provide the *Plan* with the above information, the *Plan* will provide *notice* as soon as reasonably possible, but not later than twenty-four (24) hours after receipt of your *claim*. You will be afforded a reasonable amount of time under the circumstance, but not less than forty-eight (48) hours, to provide the specified information.

Notification of Benefit Determinations of Urgent Care Claims

Notice of a *benefit determination* (whether adverse or not) will be provided as soon as possible, taking into account the medical circumstances, but no later than seventy-two (72) hours after receipt of the *claim*. However, if the *Plan* gives you *notice* of an incomplete *claim*, the *notice* will include a time period of no less than forty-eight (48) hours for you to respond with the requested specified information. The *Plan* will then provide you with the *notice* of *benefit determination* within forty-eight (48) hours after the earlier of:

1. receipt of the specified information
2. the end of the period of time given you to provide the information

If the *benefit determination* is provided orally, it will be followed in writing no later than three (3) days after the oral *notice*.

If the *urgent care claim* involves a *concurrent care decision*, a *notice* of the *benefit determination* (whether adverse or not) will be provided as soon as possible, but no later than twenty-four (24) hours after receipt of your *claim* for extension of treatment or care, as long as the *claim* is made at least twenty-four (24) hours before the prescribed period of time expires or the prescribed number of treatments ends.

Notification of Adverse Benefit Determinations of Urgent Care Claims

If an *urgent care claim* is denied in whole or in part, the denial is considered to be an *adverse benefit determination*. , The *Plan Administrator's notification* of an *adverse benefit determination* may be oral followed by written or electronic *notification* within three (3) days of the oral *notification.* The *notice* will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request

2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*

3. reference to the specific *Plan* provisions on which the determination was based

4. a description of any additional information or material needed from you to complete the *claim* and an explanation of why such material or information is necessary

5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse benefit determination,* either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in the *adverse benefit determination* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you, upon request

6. if the *adverse benefit determination* is based on the *medical necessity* or *experimental* or *investigational* treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *claimant's* medical circumstances, or a statement that such an explanation will be provided free of charge, upon request

7. a description of the expedited review process applicable to the *claim*

8. a description of the *Plan's* review or *appeal* procedures, including applicable time limits

9. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

How to File an Appeal of Urgent Care Claim

You may *appeal* any *adverse benefit determination* to the *Plan Administrator*. The *Plan Administrator* is the sole fiduciary of the *Plan* and exercises all discretionary authority and control over the administration of the *Plan* and has sole discretionary authority to determine eligibility for *Plan* benefits and to construe the terms of the *Plan*. When a *claimant* receives *notification* of an *adverse benefit determination*, the *claimant* generally has **one hundred eighty (180) days** following receipt of the *notification* in which to file a written request for an *appeal* of the decision. However, for concurrent care *claims*, the *claimant* must file the *appeal* prior to the scheduled reduction or termination of treatment. For a *claim* based on rescission of

coverage, the *claimant* must file the *appeal* within thirty (30) days. A *claimant* may submit written comments, documents, records, and other information relating to the *claim*.

The *Plan Administrator* will conduct a full and fair review of all benefit *appeals*, independently from the individual(s) who made the *adverse benefit determination* or anyone who reports to such individual(s) and without affording deference to the *adverse benefit determination*. You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your *claim* for benefits, including your *claim* file. You will also have the opportunity to submit to the *Plan Administrator* written comments, documents, records, and other information relating to your *claim* for benefits. You may also present evidence and testimony should you choose to do so; however, a formal hearing may not be allowed. The *Plan Administrator* will take into account all this information regardless of whether it was considered in the *adverse benefit determination*.

A document, record, or other information shall be considered relevant to a *claim* if it:

1. was relied upon in making the *benefit determination*
2. was submitted, considered, or generated in the course of making the *benefit determination*, without regard to whether it was relied upon in making the *benefit determination*
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that *benefit determinations* are made in accordance with plan documents and *Plan* provisions have been applied consistently with respect to all *claimants*
4. constituted a statement of policy or guidance with respect to the *Plan* concerning the denied treatment option or benefit

The period of time within which a *benefit determination* on *appeal* is required to be made shall begin at the time of receipt of a written *appeal* in accordance with the procedures of the *Plan*. This timing is without regard to whether all the necessary information accompanies the filing. Before the *Plan Administrator* issues its *final internal adverse benefit determination* based on a new or additional rationale or evidence, the *claimant* must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on *appeal* is required to allow the *claimant* time to respond.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Plan Administrator* will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the *adverse benefit determination* nor is a subordinate of any such individual. Upon request, you will be provided the identification of the medical or vocational expert(s) whose advice was obtained on behalf of the *Plan* in connection with the *adverse benefit*

determination, whether or not the advice was relied upon to make the *adverse benefit determination*.

Form and Timing of an Appeal of a Denied Urgent Care Claim

You or your *authorized representative* must file any *appeal* of an *adverse benefit determination* within one hundred eighty (180) days after receiving notification of the *adverse benefit determination*.

Requests for *appeal* which do not comply with the above requirements will not be considered.

You may *appeal* an *adverse benefit determination* of an **urgent care claim** on an expedited basis, either orally or in writing. You may *appeal* orally by calling the *Medical Management Administrator* at 1-855-778-9053. All necessary information, including the *Medical Management Administrator's benefit determination* on review, will be transmitted between the *Medical Management Administrator* and you by telephone, facsimile, or other available similarly expeditious method.

Time Period for Deciding Appeals of Urgent Care Claims

Appeals of *urgent care claims* will be decided by the *Plan Administrator* as soon as possible, taking into account the *medical emergencies*, but no later than seventy-two (72) hours after the *Plan Administrator* receives the *appeal*. A decision communicated orally will be followed-up in writing.

Notification of Appeal Denials of Urgent Care Claims

The *Plan Administrator* shall provide *notification* of the decision on an *urgent care claim* orally, but a follow-up written *notification* will be provided no later than three (3) days after the oral *notice*. The *notice* will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request

2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*

3. reference to the specific *Plan* provisions on which the *adverse benefit determination* was based

4. a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records, and other information that are relevant to the *claim*

You and your *Plan* may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office.

5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request

6. if the denied *appeal* was based on a *medical necessity*, *experimental/investigational,* or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the *Plan* to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request

7. a description of any additional material or information necessary for the *claimant* to perfect the *claim* and an explanation of why such material or information is necessary

8. a description of the *Plan's* internal and *external review* procedures and the time limits applicable to such procedures

9. a statement describing any additional *appeal* procedures offered by the *Plan* and your right to obtain information about such procedures

10. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

Concurrent Care Claims

Your *claim* for medical care or treatment is a *concurrent care claim* if your *claim* has been approved to provide an ongoing course of treatment over a period of time, which either involves a reduction or termination by the *Plan* of such course of treatment (other than by *Plan* amendment or termination), or a request by you or on your behalf to extend or expand your treatment.

If your request involves concurrent care (the continuation/reduction of an ongoing course of treatment), you may file the *claim* by writing (orally for an expedited review) to the *Medical Management Administrator.*

1. If a decision is made to reduce or terminate an approved course of treatment, you will be provided *notification* of the termination or reduction sufficiently in advance of the reduction or termination to allow you to *appeal* and obtain a determination of that *adverse benefit determination* before the benefit is reduced or terminated.

2. The *Plan* will provide you free of charge with any new or additional evidence considered, relied upon, or generated by the *Plan* (or at the direction of the *Plan*) in connection with the denied *claim*. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the *notice* of *adverse benefit determination* on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the *Plan* issues an *adverse benefit determination* or review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the *notice* of *adverse benefit determination* on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

3. A *concurrent care claim* that is an *urgent care claim* will be processed according to the initial review and *appeals* procedures and timeframes noted under the Urgent Care Claim subsection (above).

4. If a *concurrent care claim* does not involve urgent care, the request may be treated as a new benefit *claim* and decided within the timeframe appropriate to the type of *claim*, i.e., as a *pre-service claim* or a *post-service claim*. Such *claims* will be processed according to the initial review and *appeals* procedures and timeframes applicable to the claim-type, as noted under the Other Pre-Service Claims subsection (below) or the Post-Service Claims subsection listed later in this section.

5. If the *concurrent care claim* is approved, you will be *notified* orally followed by written (or electronic, as applicable) *notice* provided no later than three (3) calendar days after the oral *notice*.

Other Pre-Service Claims

Claims that require *Plan* approval prior to obtaining medical care for the *claimant* to receive full benefits under the *Plan* are considered *other pre-service claims* (e.g. a request for *pre-certification* under the Health Care Management Program). Refer to the **Heath Care Management Program** section to review the list of services that require *pre-certification.*

How to File Other Pre-Service Claims

Typically, the *other pre-service claim* is made on a *claimant's* behalf by the treating *physician*. However, it is the *claimant's* responsibility to ensure that the *other pre-service claim* has been filed. The *claimant* can accomplish this by having his or her *health care provider* contact the *Medical Management Administrator* to file the *other pre-service claim* on behalf of the *claimant*.

Other pre-service claims must *include* the following information:

1. the name of this *Plan*
2. the identity of the *claimant* (name, address, and date of birth)

3. the proposed date(s) of service
4. the name and credentials of the *health care provider*
5. an order or request from the *health care provider* for the requested service
6. the proposed place of service
7. a specific diagnosis
8. a specific proposed service code for which approval or payment is requested [current Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) format]
9. clinical information for this *Plan* to make a *medical necessity* determination

Under certain circumstances provided by federal law, if you or your *authorized representative* fail to follow the *Plan's* procedures for filing *other pre-service claims*, the *Plan* will provide *notice* of the failure and the proper procedures to be followed. This *notification* will be provided as soon as reasonably possible, but no later than five (5) days after receipt of the *claim*. You will then have up to forty-five (45) days from receipt of the *notice* to follow the proper procedures.

Notification of Benefit Determination of Other Pre-Service Care Claims

Notice of a *benefit determination* (whether adverse or not) will be provided in writing within a reasonable period appropriate to the medical circumstances, but no later than fifteen (15) days after receipt of the *claim*. However, this period may be extended one (1) time by the *Plan* for up to an additional fifteen (15) days if the *Plan* both determines that such an extension is necessary due to matters beyond its control and provides you written *notice*, prior to the end of the original fifteen (15) day period, of the circumstances requiring the extension and the date by which the *Plan* expects to render a decision. Refer to the Incomplete Claims subsection below, if such an extension is necessary due to your failure to submit the information necessary to decide the *claim*.

Notification of Adverse Benefit Determination of Other Pre-Service Care Claims

If the *other pre-service claim* is denied in whole or in part, the denial is considered to be an *adverse benefit determination*. The *Plan Administrator* shall provide written or electronic *notification* of the *adverse benefit determination*. This *notice* will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request

2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*

3. reference to the specific *Plan* provisions on which the determination was based

4. a description of any additional information or material needed from you to complete the *claim* and an explanation of why such material or information is necessary

5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse benefit determination,* either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in the *adverse benefit determination* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you, upon request

6. if the *adverse benefit determination* is based on the *medical necessity* or *experimental* or *investigational* treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *claimant's* medical circumstances, or a statement that such an explanation will be provided free of charge, upon request

7. a description of the *Plan's* review or *appeal* procedures, including applicable time limits

8. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

How to File an Appeal of Other Pre-Service Claims

You may *appeal* any *adverse benefit determination* to the *Plan Administrator*. The *Plan Administrator* is the sole fiduciary of the *Plan* and exercises all discretionary authority and control over the administration of the *Plan* and has sole discretionary authority to determine eligibility for *Plan* benefits and to construe the terms of the *Plan*. When a *claimant* receives *notification* of an *adverse benefit determination*, the *claimant* generally has **one hundred eighty (180) days** following receipt of the *notification* in which to file a written request for an *appeal* of the decision. However, for concurrent care *claims*, the *claimant* must file the *appeal* prior to the scheduled reduction or termination of treatment. For a *claim* based on rescission of coverage, the *claimant* must file the *appeal* within thirty (30) days. A *claimant* may submit written comments, documents, records, and other information relating to the *claim*.

The *Plan Administrator* will conduct a full and fair review of all benefit *appeals*, independently from the individual(s) who made the *adverse benefit determination* or anyone who reports to such individual(s) and without affording deference to the *adverse benefit determination*. You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your *claim* for benefits, including your *claim* file. You will also have the opportunity to submit to the *Plan Administrator* written comments, documents, records, and other information relating to your *claim* for benefits. You may also present evidence and testimony should you choose to do so; however, a formal

hearing may not be allowed. The *Plan Administrator* will take into account all this information regardless of whether it was considered in the *adverse benefit determination*.

A document, record, or other information shall be considered relevant to a *claim* if it:

1. was relied upon in making the *benefit determination*
2. was submitted, considered, or generated in the course of making the *benefit determination*, without regard to whether it was relied upon in making the *benefit determination*
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that *benefit determinations* are made in accordance with plan documents and *Plan* provisions have been applied consistently with respect to all *claimants*
4. constituted a statement of policy or guidance with respect to the *Plan* concerning the denied treatment option or benefit

The period of time within which a *benefit determination* on *appeal* is required to be made shall begin at the time of receipt of a written *appeal* in accordance with the procedures of the *Plan*. This timing is without regard to whether all the necessary information accompanies the filing. Before the *Plan Administrator* issues its *final internal adverse benefit determination* based on a new or additional rationale or evidence, the *claimant* must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on *appeal* is required to allow the *claimant* time to respond.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Plan Administrator* will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the *adverse benefit determination* nor is a subordinate of any such individual.

Upon request, you will be provided the identification of the medical or vocational expert(s) whose advice was obtained on behalf of the *Plan* in connection with the *adverse benefit determination*, whether or not the advice was relied upon to make the *adverse benefit determination*.

Form and Timing of an Appeal of Other-Pre-Service Claims

You or your *authorized representative* must file any *appeal* of an *adverse benefit determination* within one hundred eighty (180) days after receiving notification of the *adverse benefit determination*.

Requests for *appeal* which do not comply with the above requirements will not be considered.

All requests for a review of a denied *pre-service claim* (other than *urgent care claim*) must be in writing and should include a copy of the *adverse benefit determination*, if applicable, and any other pertinent information that you wish the *Medical Management Administrator* to review in conjunction with your *appeal*. Send all information to:

AmeriBen Medical Management
2152 S. Vineyard Ave, Suite 103
Mesa, AZ 85210

Time Period for Deciding Appeals of Other Pre-Service Claims

Appeals of other *pre-service claims* will be decided by the *Plan Administrator* within a reasonable period of time appropriate to the medical circumstances, but no later than thirty (30) days after the *Plan Administrator* receives the *appeal*. The *Plan Administrator's* decision will be provided to you in writing.

Notification of Appeal Denials of Other Pre-Service Claims

If your *appeal* is denied, in whole or in part, the *Plan Administrator* will provide written *notification* of the *adverse benefit determination* on *appeal*. The *notice* will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request

2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*

3. reference to the specific *Plan* provisions on which the *adverse benefit determination* was based

4. a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records, and other information that are relevant to the *claim*
   You and your *Plan* may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office

5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request

6. if the denied *appeal* was based on a *medical necessity*, *experimental/investigational,* or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the *Plan* to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request

7. a description of any additional material or information necessary for the *claimant* to perfect the *claim* and an explanation of why such material or information is necessary

8. a description of the *Plan's* internal and *external review* procedures and the time limits applicable to such procedures

9. a statement describing any additional *appeal* procedures offered by the *Plan* and your right to obtain information about such procedures

10. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

Second Level Appeals Process for Urgent Care, Concurrent Care, and Other Pre-Service Claims

If your *appeal* of a *claim* is denied, you or your *authorized representative* may request further review by the *Plan Administrator*. This request for a second-level *appeal* must be made in writing within sixty (60) days of the date you are *notified* of the original *appeal* decision. This second-level review is mandatory; i.e., you are required to undertake this second-level *appeal* before you may pursue civil action.

The *Plan Administrator* will promptly conduct a full and fair review of your *appeal*, independently from the individual(s) who considered your first-level *appeal* or anyone who reports to such individual(s) and without affording deference to the initial denial. You will again have access to all relevant records and other information and the opportunity to submit written comments and other information.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Plan Administrator* will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was consulted neither in connection with the *adverse benefit determination* nor the initial *appeal* denial and who is not a subordinate of any such individuals.

Second-level *appeals* of *claims* will be decided by the *Plan Administrator* within a reasonable period of time, but no later than thirty (30) days after the *Plan Administrator* receives the *appeal*. The *Plan Administrator's* decision will be provided to you in writing, and if the decision

is a second denial, the *notification* will include all of the information described in the subsection entitled Notification of Appeal Denials above.

Timeframes for the Pre-Service Claim Filing and Appeals Process

	Pre-Service Claim Types		
	Urgent Care Claim	**Concurrent Care Claim**	**Other Pre-Service Claim**
Plan must make Initial *benefit determination* as soon as possible but no later than:	Seventy-two (72) hours	Before the benefit is reduced or treatment terminated	Fifteen (15) days
Extension permitted during initial *benefit determination*?	No	No	Fifteen (15) days
Appeal review must be submitted to the *Plan* within:	One hundred eighty (180) days	One hundred eighty (180) days	One hundred eighty (180) days
Plan must make *appeal benefit determination* as soon as possible but no later than:	Seventy-two (72) hours – Thirty-six (36) hours first level and thirty-six (36) hours second level	Before the benefit is reduced or treatment terminated	Fifteen (15) days for each level of appeal
Extension permitted during *appeal* review?	No	No	No

External Review of Pre-Service Claims
Refer to the **External Review of Claims** section for the full description of the external review process under the *Plan*.

Incomplete Claims
Incomplete *pre-service claims* and/or *post-service claims* can be addressed through the extension of time described herein. If the reason for the extension is the failure to provide necessary information and the *claimant* is appropriately *notified*, This *Plan's* period of time to make a decision is suspended from the date upon which notification of the missing necessary information is sent until the date upon which the *claimant* responds or should have responded.

The *notification* will include a timeframe of at least forty-five (45) days in which the necessary information must be provided. Once the necessary information has been provided, This *Plan* will decide the *claim* within the extension described herein.

However, if the time period for the *benefit determination* is extended due to your failure to submit information necessary to decide a *claim*, the time period for making the *benefit determination* will be suspended from the date the *notice* of extension is sent to you until the earlier of:

1. the date on which you respond to the request for additional information
2. the date established by the *Plan* for the furnishing of the requested information [at least forty-five (45) days]

If the requested information is not provided within the time specified, the *claim* may be denied. If your *claim* is denied based on your failure to submit information necessary to decide the *claim*, the *Plan* may, in its sole discretion, renew its consideration of the denied *claim* if the *Plan* receives the additional information within one hundred eighty (180) days after original receipt of the *claim*. In such circumstances, you will be *notified* of the *Plan's* reconsideration and subsequent *benefit determination*.

Post-Service Claims

The *Claims Administrator* manages the *claims* and first level *appeal* process of *post-service claims.* The *Plan Administrator* manages the second-level appeal process of *post-service claims*. *Post-service claims* are *claims* that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard *claim* and an electronic bill, submitted for payment after services have been provided, are examples of *post-service claims*. A *claim* regarding rescission of coverage will be treated as *post-service claim.*

How to File a Post-Service Claim

In order to file a post-service claim, you or your *authorized representative* must submit the *claim,* in writing, on a form pre-approved by the *Plan*. Pre-approved *claim* forms are available from your *employer*.

All *claims* must be received by the *Plan* within a twelve (12) month period from the date of the expense to be eligible for coverage under the *Plan*.

All *claims* for reimbursement must include the following information:

1. the *plan participant's* name, Social Security Number, and address
2. patient's name, Social Security Number, and address if different from the *plan participant's*
3. *provider's* name, tax identification number, address, degree, and signature
4. date(s) of service
5. diagnosis
6. procedure codes (describes the treatment or services rendered)
7. assignment of benefits, signed (if payment is to be made to the *provider*)
8. release of information statement, signed
9. Coordination of Benefits (COB) information if another plan is the primary payer
10. sufficient medical information to determine whether and to what extent the expense is a covered benefit under the *Plan*

Send complete information to:

AmeriBen
P.O. Box 7186

Boise, ID 83707

Notification of Benefit Determinations of Post-Service Claims

The *Plan* will *notify* you or your *authorized representative* of its *benefit determination* (whether adverse or not), in writing, within a reasonable period of time, but not later than thirty (30) days after receipt of the *claim*. However, this period may be extended one (1) time by the *Plan* for up to an additional fifteen (15) days if the *Plan* both determines that such an extension is necessary due to matters beyond its control and provides you written *notice*, prior to the end of the original fifteen (15) day period, of the circumstances requiring the extension and the date by which the *Plan* expects to render a decision.

The applicable time period for the benefit determination begins when your claim is filed in accordance with the reasonable procedures of the *Plan*, even if you haven't submitted all the information necessary to make a benefit determination. Refer to the Incomplete Claims subsection for information regarding incomplete *pre-service claims* and *post-service claims*.

The applicable time period for the *benefit determination* begins when your *claim* is filed in accordance with the reasonable procedures of the *Plan*, even if you haven't submitted all the information necessary to make a *benefit determination*. However, if the time period for the *benefit determination* is extended due to your failure to submit information necessary to decide a *claim*, the time period for making the *benefit determination* will be suspended from the date the *notice* of extension is sent to you until the earlier of: (a) the date on which you respond to the request for additional information, or (b) the date established by the *Plan* for the furnishing of the requested information [at least forty-five (45) days].

If your *claim* is denied based on your failure to submit information necessary to decide the *claim*, the *Plan* may, in its sole discretion, renew its consideration of the denied *claim* if the *Plan* receives the additional information within one hundred eighty (180) days after original receipt of the *claim*. In such circumstances, you will be *notified* of the *Plan's* reconsideration and subsequent *benefit determination*.

Notification of Adverse Benefit Determination of a Post-Service Claim

If a *claim* is denied in whole or in part, the denial is considered to be an *adverse benefit determination*. The *Plan Administrator* shall provide written or electronic notification of the *adverse benefit determination*. The *notice* will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. Identification of the *claim*, including date of service, name of *provider*, *claim* amount (if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the *claimant* as soon as feasible upon request.

2. The specific reason(s) for the *adverse benefit determination*, including the denial codes and its corresponding meaning, and the *Plan's* standard, if any, used in denying the *claim*.

3. Reference to the specific *Plan* provisions on which the determination was based.

4. A description of any additional information or material needed from you to complete the *claim* and an explanation of why such material or information is necessary.

5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse benefit determination* either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in the *adverse benefit determination* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

6. If the *adverse benefit determination* is based on the *medical necessity* or *experimental* or *investigational* treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *claimant's* medical circumstances, or a statement that such an explanation will be provided free of charge, upon request.

7. A description of the *Plan's* review or *appeal* procedures, including applicable time limits with respect to any *claim* denied after an *appeal*.

8. Information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process.

How to File an Appeal of a Post-Service Claim

You may *appeal* any *adverse benefit determination* to the *Plan Administrator*. The *Plan Administrator* is the sole fiduciary of the *Plan*, and exercises all discretionary authority and control over the administration of the *Plan* and has sole discretionary authority to determine eligibility for *Plan* benefits and to construe the terms of the *Plan*. When a *claimant* receives *notification* of an *adverse benefit determination*, the *claimant* generally has one hundred eighty (180) days following receipt of the *notification* in which to file a written request for an *appeal* of the decision. However, for concurrent care claims, the *claimant* must file the *appeal* prior to the scheduled reduction or termination of treatment. For a *claim* based on rescission of coverage, the *claimant* must file the *appeal* within thirty (30) days. A *claimant* may submit written comments, documents, records, and other information relating to the *claim*.

The *Plan Administrator* will conduct a full and fair review of all benefit *appeals*, independently from the individual(s) who made the *adverse benefit determination* or anyone who reports such

individual(s) and without affording deference to the *adverse benefit determination*. You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your *claim* for benefits, including your *claim* file. You will also have the opportunity to submit to the *Plan Administrator* written comments, documents, records, and other information relating to your *claim* for benefits. You may also present evidence and testimony should you choose to do so; however a formal hearing may not be allowed. The *Plan Administrator* will take into account all this information regardless of whether it was considered in the *adverse benefit determination*.

A document, record, or other information shall be considered relevant to a *claim* if it:

1. was relied upon in making the *benefit determination*
2. was submitted, considered, or generated in the course of making the *benefit determination*, without regard to whether it was relied upon in making the *benefit determination*
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that *benefit determination*s are made in accordance with *Plan* documents and *Plan* provisions have been applied consistently with respect to all *claimants*
4. constituted a statement of policy or guidance with respect to the *Plan* concerning the denied treatment option or benefit

The period of time within which a *benefit determination* on *appeal* is required to be made shall begin at the time an *appeal* is filed in writing in accordance with the procedures of the *Plan*. This timing is without regard to whether all the necessary information accompanies the filing.

Before the *Plan Administrator* issues its *final internal adverse benefit determination* based on a new or additional rationale or evidence, the *claimant* must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on *appeal* is required to allow the *claimant* time to respond.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Plan Administrator* will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the *adverse benefit determination* nor is a subordinate of any such individual.

Upon request, you will be provided the identification of the medical or vocational expert(s) whose advice was obtained on behalf of the *Plan* in connection with the *adverse benefit determination*, whether or not the advice was relied upon to make the *adverse benefit determination*.

Form and Timing of an Appeal of a Denied Post-Service Claim

You or your *authorized representative* must file any *appeal* of an *adverse benefit determination* within one hundred eighty (180) days after receiving *notification* of the *adverse benefit determination*.

Requests for *appeal* which do not comply with the above requirements will not be considered.

All requests for a review of a denied *post-service claim* must be in writing and should include a copy of the *adverse benefit determination* and any other pertinent information that you wish the *Plan Administrator* to review in conjunction with your *appeal*. Send all information to:

AmeriBen
Attention: Appeals Coordination
P.O. Box 7186
Boise, ID 83707

Time Period for Deciding Appeals

Appeals of *post-service claims* will be decided by the *Plan Administrator* within a reasonable period of time, but not later than thirty (30) days after the *Plan Administrator* receives the *appeal*. The *Plan Administrator's* decision will be provided to you in writing.

Notification of Appeal Denials of Post-Service Claims

If your *appeal* is denied, the *Plan Administrator's* written *notification* will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. Identification of the *claim*, including date of service, name of *provider*, *claim* amount (if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the *claimant* as soon as feasible upon request.

2. The specific reason(s) for the *adverse benefit determination*, including the denial codes and its corresponding meaning, and the *Plan's* standard, if any, used in denying the *claim.*

3. Reference to the specific *Plan* provisions on which the *adverse benefit determination* was based.

4. A statement regarding your right, upon request and free of charge, to access and receive copies of documents, records, and other information that are relevant to the *claim.* You and your *Plan* may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office.

5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline protocol, or other similar criterion was relied upon in denying the *appeal* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

6. If the denied *appeal* was based on a *medical necessity*, *experimental/investigational* or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the *Plan* to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request.

7. A statement describing any additional *appeal* procedures offered by the *Plan* and your right to obtain information about such procedures.

8. Information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process.

Second Level Appeal Process of Post-Service Claims

The *Plan Administrator* or his/her designee manages the second-level *appeal* process for *post-service claim decisions*.

The *Plan Administrator* or his/her designee will be identified in the *notification* of denial of your first-level *appeal* and will not be the individual who made the original decision regarding the denial of your first-level *appeal* or a subordinate of such individual.

If your *appeal* of a *claim* is denied, you or your *authorized representative* may request further review by the *Plan Administrator*. This request for a second-level appeal must be made, in writing, within sixty (60) days of the date you are *notified* of the original *appeal* decision.

The *Plan Administrator* will promptly conduct a full and fair review of your *appeal*, independently from the individual(s) who considered your first level *appeal* or anyone who reports to such individual(s) and without affording deference to the initial denial. You will again have access to all relevant records and other information and the opportunity to submit written comments and other information, as described in more detail under the section entitled Post-Service Claims above.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Plan Administrator* will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was consulted neither in

connection with the *adverse benefit determination* nor the initial *appeal* denial and who is not a subordinate of any such individuals.

Second-level appeals of *post-service claims* will be decided by the *Plan Administrator* at the next regularly scheduled Trust meeting following receipt of the *appeal*. The *Plan Administrator's* decision will be provided to you in writing, and if the decision is a second denial, the *notification* will include all of the information described in the provision entitled Notification of Appeal Denials above.

Timeframes for the Post-Service Claim Filing and Appeal Process

OVERVIEW OF CLAIMS AND APPEALS TIMEFRAMES OF POST-SERVICE CLAIMS	
Plan must make initial benefit *determination* as soon as possible but no later than:	30 days
Extension permitted during initial *benefit determination*?	15 days
Appeal review must be submitted to the *Plan* within:	180 days
Plan must make *appeal benefit determination* as soon as possible but no later than:	30 days per benefit appeal
Extension permitted during *appeal* review?	No

External Review Rights

If your final *appeal* for a *claim* is denied, you will be *notified* in writing that your *claim* is eligible for an *external review* and you will be informed of the time frames and the steps necessary to request an *external review*. You must complete all levels of the internal **Claims and Appeals** procedures before you can request a voluntary *external review*.

If you decide to seek *external review*, an *Independent Review Organization* (*IRO*) will be assigned your *claim*, and the *IRO* will work with a neutral, independent clinical reviewer with appropriate medical expertise. The *IRO* does not have to give deference to any earlier *claims* and *appeals* decisions, but it must observe the written terms of the *Plan* document. In other words, the *IRO* is not bound by any previous decision made on your *claim*. The ultimate decision of the IRO will be binding on you, the *Third Party Administrator*, and the *Plan*.

External Review of Claims

If your *appeal* is denied, and the *claim* is one for which an *external review* is available, you or your *authorized representative* may request further review by an *Independent Review Organization* (*IRO*). This request for *external review* must be made, in writing, within four (4) months of the date you are *notified* of an *adverse benefit determination* or *final internal adverse benefit determination*. *External review* is only available if the *final adverse benefit determination* involves a *claim*: (1) denied based upon a rescission of coverage or (2) which involves medical judgment (*medical necessity*, appropriateness of treatment, health care setting, level of care, or effectiveness of covered benefit) or a determination that treatment is

experimental or *investigational*, which is to be decided by the external reviewer. There is no external *appeal* for *final adverse benefit determinations* that a person is not eligible for coverage under the *Plan*.

Within five (5) business days following the date of receipt of the *external review* request, the *Plan* will complete a preliminary review of the request to determine whether:

1. the *claimant* is or was covered under the *Plan* at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the *Plan* at the time the health care item or service was provided
2. the *adverse benefit determination* or the *final adverse benefit determination* does not relate to the *claimant's* failure to meet the requirements for eligibility under the terms of the group health *Plan* (e.g., worker classification or similar determination)
3. the *claimant* has exhausted the *Plan's* internal *appeal* process
4. the *claimant* has provided all the information and forms required to process an *external review*

The *Plan* will notify the *claimant* within one (1) business day of completion of its preliminary review if:

1. the request is complete but not eligible for *external review*, in which case the *notice* will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration [toll-free number 866-444-EBSA (3272)];

2. the request is not complete, in which case the *notice* will describe the information or materials needed to make the request complete, and allow the *claimant* to perfect the request for *external review* within the four (4) month filing period, or within the forty-eight (48) hour period following receipt of the *notification*, whichever is later

Note: If the *adverse benefit determination* or *final internal adverse benefit determination* relates to a *plan participant's* or beneficiary's failure to meet the requirements for eligibility under the terms of the *Plan*, it is not within the scope of the *external review* process, and no *external review* may be taken.

If the request is complete and eligible, the *Plan Administrator* will assign the request to an *IRO*. Once that assignment is made, the following procedure will apply:

1. The assigned *IRO* will utilize legal experts where appropriate to make coverage determinations under the *Plan*.

2. The assigned *IRO* will timely *notify* the *claimant*, in writing, of the request's eligibility and acceptance for *external review*. This *notice* will include a statement that the *claimant* may submit in writing to the assigned *IRO* within ten (10) business days following the date of receipt of the *notice* additional information that the *IRO* must

consider when conducting the *external review*. The *IRO* is not required to, but may, accept and consider additional information submitted after ten (10) business days.

3. Within five (5) business days after the date of assignment of the IRO, the *Plan* must provide to the assigned *IRO* the documents and any information considered in making the *adverse benefit determination* or *final internal adverse benefit determination*. Failure by the *Plan* to timely provide the documents and information must not delay the conduct of the *external review*. If the *Plan* fails to timely provide the documents and information, the assigned *IRO* may terminate the *external review* and make a decision to the *adverse benefit determination* or *final internal adverse benefit determination*. Within one (1) business day after making the decision, the *IRO* must *notify* the *claimant* and the *Plan*.

4. Upon receipt of any information submitted by the *claimant*, the assigned *IRO* must within one (1) business day forward the information to the *Plan*. Upon receipt of any such information, the *Plan* may reconsider its *adverse benefit determination* or *final internal adverse benefit determination* that is the subject of the *external review*. Reconsideration by the *Plan* must not delay the *external review*. The *external review* terminated as a result of the reconsideration only if the *Plan* decides, upon completion of its reconsideration, to reverse its *adverse benefit determination* or *final internal adverse benefit determination* and provide coverage or payment. Within one (1) business day after making such a decision, the *Plan* must provide written *notice* of its decision to the *claimant* and the assigned *IRO*. The assigned *IRO* must terminate the *external review* upon receipt of the *notice* from the *Plan*.

5. The *IRO* will review all of the information and documents timely received. In reaching a decision, the assigned *IRO* will review the *claim* de novo and not be bound by any decisions or conclusions reached during the *Plan's* internal *claims* and *appeals* processes. In addition to the documents and information provided, the assigned *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, will consider the following in reaching a decision:

    a. the *claimant's* medical records
    b. the attending health care professional's recommendation
    c. reports from appropriate health care professionals and other documents submitted by the *Plan*, *claimant*, or the *claimant's* treating *provider*
    d. the terms of the *claimant's Plan* to ensure that the *IRO's* decision is not contrary to the terms of the *Plan*, unless the terms are inconsistent with applicable law
    e. appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations
    f. any applicable clinical review criteria developed and used by the *Plan*, unless the criteria are inconsistent with the terms of the *Plan* or with applicable law

g. the opinion of the *IRO's* clinical reviewer or reviewers after considering the information described in this *notice* to the extent the information or documents are available

6. The assigned *IRO* must provide written notice of the final *external review* decision within forty-five (45) days after the *IRO* receives the request for the *external review*. The *IRO* must deliver the *notice* of final *external review* decision to the *claimant* and the *Plan*.

7. The assigned *IRO's* decision notice will contain the following:

    a. A general description of the reason for the request for *external review*, including information sufficient to identify the *claim* (including the date or dates of service, the health care *provider*, the *claim* amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the reason for the previous denial).
    b. The date the *IRO* received the assignment to conduct the *external review* and the date of the *IRO* decision.
    c. The references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision.
    d. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision.
    e. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health *Plan* or to the *claimant*.
    f. A statement that judicial review may be available to the *claimant*.
    g. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

Generally, a *claimant* must exhaust the *Plan's* **Claims and Appeals** procedures in order to be eligible for the *external review* process. However, in some cases the *Plan* provides for an expedited *external review* if:

1. The *claimant* receives an *adverse benefit determination* that involves a medical condition for which the time for completion of the *Plan's* internal **Claims and Appeals** procedures would seriously jeopardize the *claimant's* life or health or ability to regain maximum function and the *claimant* has filed a request for an expedited internal review; or

2. The *claimant* receives a *final internal adverse benefit determination* that involves a medical condition where the time for completion of a standard *external review* process would seriously jeopardize the *claimant's* life or health or the *claimant's* ability to regain maximum function, or if the *final internal adverse benefit determination* concerns an

admission, availability of care, continued stay, or health care item, or service for which the *claimant* received *emergency services*, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited *external review*, the *Plan* must determine and *notify* the *claimant* whether the request satisfies the requirements for expedited review, including the eligibility requirements for *external review* listed above. If the request qualifies for expedited review, it will be assigned to an *IRO*. The *IRO* must make its determination and provide a *notice* of the decision as expeditiously as the *claimant's* medical condition or circumstances require, but in no event more than seventy-two (72) hours after the *IRO* receives the request for an expedited *external review*. If the original *notice* of its decision is not in writing, the *IRO* must provide written confirmation of the decision within forty-eight (48) hours to both the *claimant* and the *Plan*.

Appointment of Authorized Representative

A *plan participant* is permitted to appoint an *authorized representative* to act on his or her behalf with respect to a benefit *claim* or *appeal* of a denial. In connection with a *claim* involving urgent care, the *Plan* will permit a health care professional with knowledge of the *plan participant's* medical condition to act as the *plan participant's authorized representative*. In the event a *plan participant* designates an *authorized representative*, all future communications from the *Plan* will be with the representative, rather than the *plan participant*, unless the *plan participant* directs the *Plan Administrator*, in writing, to the contrary.

Physical Examinations

The *Plan* reserves the right to have a *physician* of its own choosing examine any *plan participant* whose condition, *illness,* or *injury* is the basis of a *claim*. All such examinations shall be at the expense of the *Plan*. This right may be exercised when and as often as the *Plan* may reasonably require during the pendency of a *claim*. The *plan participant* must comply with this requirement as a necessary condition to coverage.

Managed Care Recommendations

The *Plan*, together with the *Medical Management Administrator* and the *Third Party Administrator*, have the option to override certain *Plan* limitations, exclusions, or *pre-certification* requirements when it is in the best interest of the *Plan* to allow a more cost-effective type of alternative care. Subject to all other terms and conditions of this *Plan* as set forth in this *Plan* document, if a *plan participant* suffers from a covered *injury* or *illness* which requires treatment for which there is no *network provider*, as confirmed by the medical review administrator and approved by the reinsurance carrier, the *Plan* may elect to pay for treatment by an *non-network provider* at the *network provider* level.

Autopsy

The *Plan* reserves the right to have an autopsy performed upon any deceased *plan participant* whose condition, *illness*, or *injury* is the basis of a *claim*. This right may be exercised only where not prohibited by law.

Payment of Benefits
All benefits under this *Plan* are payable, in U.S. Dollars, to the *plan participant* whose *illness* or *injury*, or whose covered *dependent's illness* or *injury*, is the basis of a *claim*. In the event of the death or incapacity of a *plan participant* and in the absence of written evidence to this *Plan* of the qualification of a guardian for his or her estate, this *Plan* may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of this *Plan*, is or was providing the care and support of such *employee*.

Assignments
Benefits for medical expenses covered under this *Plan* may be assigned by a *plan participant* to the *provider* as consideration in full for services rendered; however, if those benefits are paid directly to the *employee*, the *Plan* shall be deemed to have fulfilled its obligations with respect to such benefits. The *Plan* will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the *plan participant* and the assignee, has been received before the proof of loss is submitted.

No *plan participant* shall at any time, either during the time in which he or she is a *plan participant* in the *Plan*, or following his or her termination as a *plan participant,* in any manner, have any right to assign his or her right to sue to recover benefits under the *Plan*, to enforce rights due under the *Plan* or to any other causes of action which he or she may have against the *Plan* or its fiduciaries.

A *provider* which accepts an *assignment of benefits*, in accordance with this *Plan* as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

Non U.S. Providers
Medical expenses for care, supplies, or services which are rendered by a *provider* whose principal place of business or address for payment is located outside the United States (a non U.S. *provider*) are payable under the *Plan*, subject to all *Plan* exclusions, limitations, maximums and other provisions, under all of the following conditions:

1. benefits may not be assigned to a non U.S*. provider*
2. the *plan participant* is responsible for making all payments to non U.S. *providers*, and submitting receipts to the *Plan* for reimbursement;
3. benefit payments will be determined by the *Plan* based upon the exchange rate in effect on the *incurred* date
4. the non U.S. *provider* shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements
5. *claims* for benefits must be submitted to the *Plan* in English

Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the *Plan's* terms, conditions, limitations or exclusions, or should otherwise not have been paid by the *Plan*. As such this *Plan* may pay benefits that are later found to be greater than the *maximum allowable charge*. In this case, this *Plan* may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the *Plan* pays benefits exceeding the amount of benefits payable under the terms of the *Plan*, the *Plan Administrator* has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the *plan participant* or *dependent* on whose behalf such payment was made.

A *plan participant*, *dependent*, *provider*, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the *Plan* or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the *Plan* within thirty (30) days of discovery or demand. The *Plan Administrator* shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The *Plan Administrator* shall have the sole discretion to choose who will repay the *Plan* for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a *plan participant* or other entity does not comply with the provisions of this section, the *Plan Administrator* shall have the authority, in its sole discretion, to deny payment of any *claims* for benefits by the *plan participant* and to deny or reduce future benefits payable (including payment of future benefits for other *injuries* or *illnesses*) under the *Plan* by the amount due as reimbursement to the *Plan*. The *Plan Administrator* may also, in its sole discretion, deny or reduce future benefits (including future benefits for other *injuries* or *illnesses*) under any other group benefits plan maintained by the *Plan Sponsor*. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the *Plan* or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this *Plan* and agree to submit *claims* for reimbursement in strict accordance with their State's health care practice acts, ICD-9/ICD-10 or CPT standards, *Medicare* guidelines, HCPCS standards, or other standards approved by the *Plan Administrator* or insurer. Any payments made on *claims* for reimbursement not in accordance with the above provisions shall be repaid to the *Plan* within thirty (30) days of discovery or demand or incur prejudgment interest of 1.5% per month. If the *Plan* must bring an action against a *plan participant*, *provider,* or other person or entity to enforce the provisions of this section, then that *plan participant*, *provider,* or other person or entity agrees to pay the *Plan's* attorneys' fees and costs, regardless of the action's outcome.

Further, *plan participant* and/or their *dependents*, beneficiaries, estate, heirs, guardian, personal representative, or assigns (*plan participant*) shall assign or be deemed to have assigned to the *Plan* their right to recover said payments made by the *Plan*, from any other party and/or recovery for which the *plan participant(s)* are entitled, for or in relation to facility-acquired condition(s), *provider* error(s), or damages arising from another party's act or omission for which the *Plan* has not already been refunded.

The *Plan* reserves the right to deduct from any benefits properly payable under this *Plan* the amount of any payment which has been made:

1. in error
2. pursuant to a misstatement contained in a proof of loss or a fraudulent act
3. pursuant to a misstatement made to obtain coverage under this *Plan* within two (2) years after the date such coverage commences
4. with respect to an ineligible person
5. in anticipation of obtaining a recovery if a *plan participant* fails to comply with the *Plan's* **Reimbursement and Recovery Provision** provisions
6. Pursuant to a *claim* for which benefits are recoverable under any policy or act of law providing for coverage for occupational *injury* or *disease* to the extent that such benefits are recovered
   This provision (6) shall not be deemed to require the *Plan* to pay benefits under this *Plan* in any such instance.

The deduction may be made against any *claim* for benefits under this *Plan* by a *plan participant* or by any of his or her covered *dependents* if such payment is made with respect to the *plan participant* or any person covered or asserting coverage as a *dependent* of the *plan participant*.

If the *Plan* seeks to recoup funds from a *provider*, due to a *claim* being made in error, a *claim* being fraudulent on the part of the *provider*, and/or the *claim* that is the result of the *provider's* misstatement, said *provider* shall, as part of its *assignment of benefits* from the *Plan*, abstain from billing the *plan participant* for any outstanding amount(s).